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Universal access to essential oral healthcare through a priority-setting approach

Tan Nguyen | 2025 Jeff Cheverton Memorial Scholar
PhD Candidate, Health Economics Group,
Public Health and Preventive Medicine,
Monash University

Casual Research Fellow, Deakin Health Economics,
Institute for Health Transformation, Deakin University

Senior Policy and Research Officer,
Dental Health Services Victoria

Adj A/Prof Rebecca Haddock
Executive Director | Knowledge Exchange
Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association Limited

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Key messages

- Cost continues to be the most frequently reported barrier to accessing oral healthcare. Addressing this challenge will require reforms to payment models and pricing structures to improve affordability and equity in access.
- While current funding models offer a strong foundation for reform, government support is presently directed toward low-income and priority populations. There is an opportunity to build on these targeted programs and progress toward a more integrated, population-based approach to oral healthcare.
- The absence of a nationally agreed definition of what dental services should be government funded, limits the ability to allocate resources effectively. Adopting the WHO's concept of essential oral healthcare would provide a clear, evidence-based framework for defining service coverage.
- By building upon the priority-setting approach, the Australian Government can work towards integrating oral health into the public health system with incremental funding changes. This should be enabled by including dental practitioners and dental services using the Australian health technology assessment (HTA) process.

Recommendations

1. **Define essential oral healthcare in Australia**: Establish a clear, evidence-based definition of essential oral healthcare in Australia, aligned with the WHO framework, to guide resource allocation and ensure equitable access.

2. **Implement a formal priority-setting approach**: A structured framework, such as the Assessing Cost Effectiveness of Oral Health Preventive Interventions (ACE-Oral Health Prevention) should be adopted, to support funding policy decision-making in oral healthcare, as successfully applied in other health areas.

3. **Integrate oral healthcare into HTA processes:** To enable oral healthcare funding decisions and ensure investments are evidence-based, a priority-setting approach must be taken and its outcomes considered by existing HTA process mechanisms.

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Background

Dentistry is expensive

In Australia, dentistry is expensive. Unlike accessing elective surgery or seeing a cardiologist in a public hospital, services typically covered by Medicare, most oral healthcare in Australia falls outside the universal healthcare insurance scheme.

For example, over the 2022-23 financial year, $12.5 billion was spent on oral healthcare (AIHW, 2024a); with approximately 61% of this expenditure attributable to spending by individuals and families (non-government) (AIHW, 2024a)[1].

In this regard, consumers bear a significant share of dental care costs through out-of-pocket payments, making dental services one of the highest individual health expenses, averaging $291 per person, second only to non-government subsidised medications at an average of $569 per person (AIHW, 2024a). This is also in contrast to out-of-pocket spending for referred and unreferred medical services at $238, and hospital services at $132 (AIHW, 2024a).

Compared to other health services, more people are reporting cost as a barrier to seeing a dental practitioner (ABS, 2024). This challenge is not only limited to low-income individuals or households, but is being experienced across all levels of socioeconomic disadvantage, with the most significant impact felt by those in the lowest socioeconomic group (ABS, 2024).

- The most common reason people aged 15 and over delay or avoid seeing a dental practitioner is due to cost (ABS, 2024).
- Of Australians aged 15 and over, 18% of people reported costs as a barrier to oral healthcare when needed (ABS, 2024)[2].
- One in ten people in the least socio-economically disadvantaged group report costs as a barrier to accessing oral healthcare, compared to one in three people in the most disadvantaged group (ABS, 2024).

[1] Individuals contributed $7.6 billion of the total health expenditure for dental health services in 2022-23 (data table A6; AIHW 2024a).

[2] Of 13,467 people surveyed, 2,376 individuals stated that the cost was reason to delay or did not see a dental practitioner (data table 14.1; ABS, 2024)

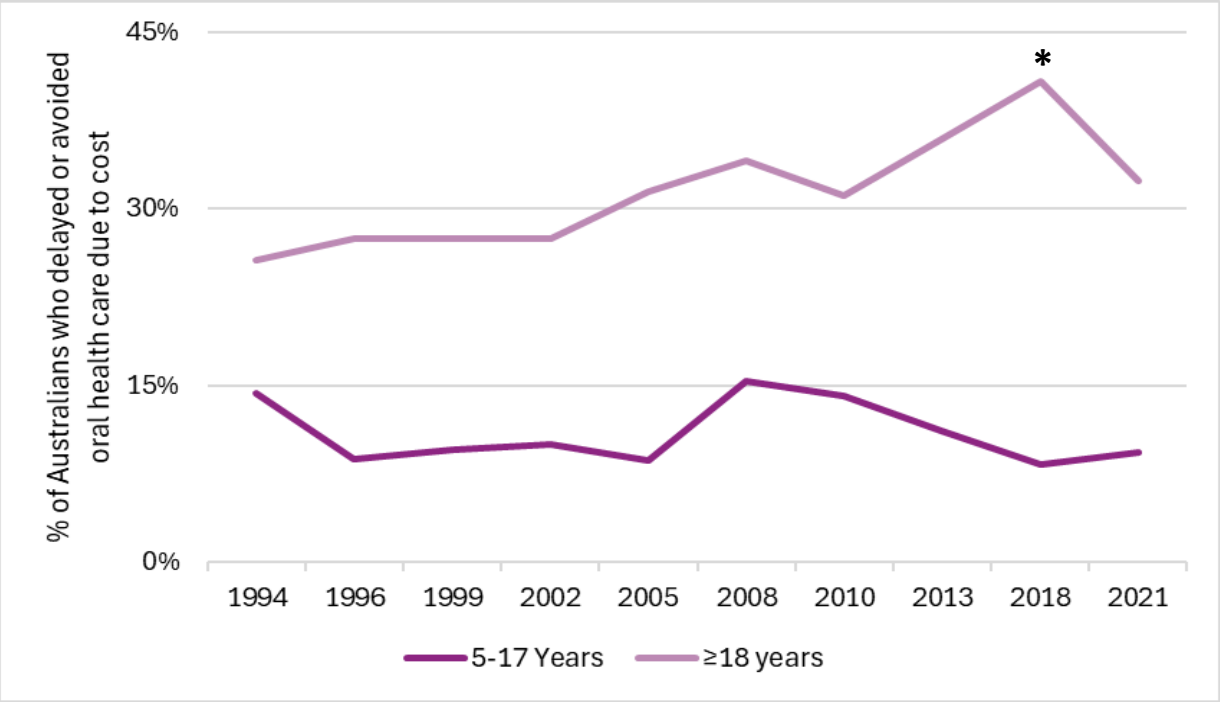

*Figure 1. Delayed or avoided oral health care due to cost: the National Dental Telephone Survey (AIHW, 2024). Financial barriers to accessing oral healthcare increased significantly for adults between 2010 and 2017, and for children between 2005 and 2008 (AIHW, 2024). * The decline in adults (>18 years) delaying oral healthcare due to costs may be attributed to growth in real household disposable income during this period (2018-2021) (Beckers et al., 2024).*

Impact of high oral healthcare costs

Among adults (≥18 years), trends in financial hardship related to oral healthcare have only continued to increase over time (AIHW, 2024) (Figure 1).[3] In 2021, for example, 32% of Australian adults delayed or avoided oral healthcare due to costs, compared to 26% in 1994 (AIHW, 2024).[4]

In contrast, the proportion of children aged 5–17 years who delayed or avoided oral healthcare due to cost decreased over the same period, from 14% to 9% (AIHW, 2024) (Figure 1).[5]

The disparity between adults and children likely reflects the limited financial protection for essential oral healthcare[4] which is not only vital for meeting Australians' health needs but also considered essential for quality of life (Brennan et al., 2020; Srivastava et al., 2017; Naidoo et al., 2024).

For example among those most severely deprived, that is those lacking at least three essential items (e.g. items for children,

[3] Cost interactive 7.

[4] Cost interactive 7.

[5] Cost interactive 5.

emergency savings, home insurance), 47% continue to express concerns about accessing dental treatment when needed (*Material Deprivation in Australia: The Essentials of Life* report ; Naidoo et al., 2024).

If not addressed, ongoing oral health issues can become risk factors for chronic conditions such as diabetes (Fu et al., 2020), or result in visible dental deterioration that affects social confidence and psychological wellbeing (World Dental Federation, nd). These impacts can create further barriers to improving financial circumstances.

For example, difficulties in gaining or keeping employment due to oral health related stigma, or reduced productivity through absenteeism caused by untreated dental problems (Sanders and Spencer, 2004; Singhal et al., 2013).

Consistent, preventative dental care is the most effective way to avoid the escalation of oral health conditions into more complex and costly problems. However, with cost remaining a major barrier, many Australians are forced to seek alternative ways to fund essential dental care, often at a point when their needs are more urgent and treatment is more expensive (Figure 2).

Superannuation is being used to fund dental treatment

Issues of affordability may have led to an increase in the number of consumers accessing superannuation to fund dental treatment under compassionate grounds. The number of applications increasing six-fold over the five year period from 2018/19 to 23/24 (financial years) (ATO, 2024). From 2021 to 2023, around half of the proportion of superannuation released for medical treatment was for dental treatment (Figure 2), indicating a marked increase in unmet oral health needs (ATO, 2024).

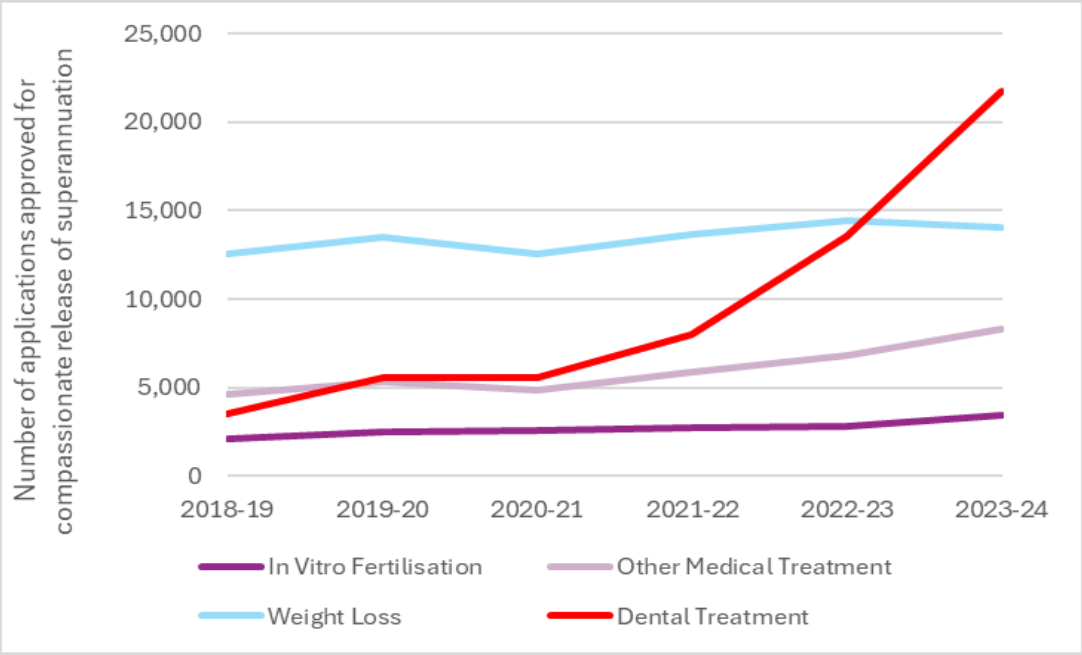

Figure 2. Growth in the number of applications approved by the Australian Tax Office for compassionate release of superannuation (2018-19 to 2023-24) (ATO, 2024).

Universal access to oral health care

To ensure equitable access to essential oral healthcare, reduce out- of- pocket costs and address long standing disparities, Australia must consider shifting to a universal approach to oral healthcare delivery; one that ensures access to oral healthcare across three dimensions (Winkelmann et al., 2022):

- the population covered,
- the proportion of costs covered, and
- the services covered.

To date, oral healthcare in Australia has been delivered through a free market model and estimates to implement a universal dental scheme have been projected in the excess of $5 billion annually (Duckett et al., 2019; PBO, 2024).

However, modelled universal dental schemes are underpinned by a dental fee schedule that has not been formally evaluated for cost-effectiveness, creating uncertainty about its value as an investment (Nguyen et al., 2025).

Nevertheless, despite the inertia seen in Australia towards developing a universal oral healthcare system, interest is growing internationally. The World Health Organization (WHO) has developed, and is implementing, the Global Oral Health Strategy and Action Plan 2023-2030 to support a global oral health policy agenda (WHO, 2024).

This strategy has identified financial protection and improving access to oral healthcare as an output measure to monitor the integration of oral health with universal health coverage (WHO, 2024).

Within this context, the WHO has called for Member States, which includes Australia, to develop a nationally tailored oral healthcare package; supported by a stakeholder engagement process to identify-cost effective oral health interventions for inclusion in the country's universal health coverage framework (WHO, 2024).

This Issues Brief outlines recommendations to support a fiscal incremental approach to achieving universal access to essential oral healthcare in Australia.

Financial barriers to affordable oral healthcare

In 2021-22, Australia ranked sixth out of 31 countries in the OECD in terms of oral healthcare funding; with the majority of spending occurring through out-of-pocket costs to consumers ($6.67B) and health insurance funds ($2.16B) (Hopcraft, 2024). Of the government spending allocated for oral healthcare (Federal $1.3B / State $0.96B), one third was directed towards subsidising private health insurance (Hopcraft, 2024).

Over time, this limited government investment has impacted the provision of public dental services in Australia (Holden, 2018; Holden et al., 2022), resulting in high costs for consumers and inequities of access.

Free market dentistry in Australia

In Australia, dentistry operates largely within a free-market system. Dental services are delivered by private practitioners operating outside government price regulation, with over 77% of oral healthcare provided by the for-profit private sector (Gnanamanickam et al., 2018).

The market is largely shaped by dynamics between consumer demand and service availability (ADVOCATE Consortium et al., 2020), pricing out those unable to afford services. As a result, only around half of Australian adults attend a regular dental checkup at least once a year (AIHW, 2024c).

Dentistry free market in Australia

Predominantly Private System:
- Most dental care is delivered through private dental clinics.
- Patients typically pay out-of-pocket or use private health insurance (extras cover) to help with costs.

Limited Public Dental Services:
- Publicly funded dental care is available, but mainly to eligible groups, such as children (e.g. through the Child Dental Benefits Schedule)

Low-income adults and concession card holders
- Public dental services often involve long wait times and limited scope of care.

Fee-For-Service Model:
- Dentists set their own prices—there is no government regulation of fees.
- This leads to significant price variation between providers and regions.

Market Competition:
- Dental clinics compete for patients through pricing, reputation, technology, and service offerings.
- Consumers can choose their provider, but price transparency is often lacking.

Insurance and Out-of-Pocket Costs:
- Private health insurance offers some coverage for dental, but usually with caps and limits.
- Many Australians pay significant out-of-pocket expenses, making cost a barrier to access.

Oral healthcare policy misalignment

Successive Australian Government policies have aimed to improve access to oral healthcare by disrupting the dentistry free market, however these have been ad hoc and targeted to specific Australian populations, without clear evidence that targeted populations are more appropriate than addressing the needs of the general population (Akers et al., 2017; Nguyen et al., 2023; Wright and List, 2012).

In general, these approaches have been short-term in focus, leading to funding policies that ultimately undermined their intended oral health outcomes. For example, the Chronic Disease Dental Scheme (CDDS).

The Chronic Disease Dental Scheme (CDDS).

The CDDS (2008-2012) was introduced by the government to improve access to oral healthcare. Under this scheme the private sector was able to deliver government subsidised oral healthcare to consumers. Eligible consumers could claim up to A$4,250 per person over a two-year period for dental services (Akers et al., 2017). However, access to the scheme also required approval from a general medical practitioner and a diagnosis of a chronic disease adversely affecting oral health (Crocombe et al., 2015).

The CDDS' focus on disease, rather than on oral disease prevention, resulted in expenditure incentivised for expensive non-preventive complex dental treatments (Crocombe et al., 2015; Lam, 2012) with some general practitioners reporting that they felt pressured to provide dental referrals to consumers who may not necessarily benefit, and even by dentists as a way to drive personal remuneration (Lam, 2012; Weerakoon et al., 2014).

Additionally, as the CDDS was non-means tested it was found to be generally confusing for general practitioners, dentists, and consumers alike (Weerakoon et al., 2014). The cost of the CDDS over the five year period it was implemented was $2.8 billion (Crocombe et al., 2015).

Not only was the CDDS expensive to taxpayers (Crocombe et al., 2015; Lam, 2012), but it also drove geographic inequities across the country, with uptake clustered in urban areas and higher income regions. Particularly in NSW with two thirds of the schemes coming from the state, raising questions about the scheme's integrity and over-servicing (Crocombe et al., 2015; Kraatz et al., 2014; Lam, 2012; Palfreeman and Zoellner, 2012; ANAO, 2014).

Challenges related to the policy design (e.g. lack of targeting and misuse) and concerns relating to the financial sustainability of the scheme contributed to its discontinuation in 2012 (Akers et al., 2017; Lam et al., 2015, 2014).

Since its closure, there have been no concerted efforts to reform the free-market structure of adult dental care in Australia and as a result, access to oral healthcare remains challenging for many adults and barriers to essential services for vulnerable populations are perpetuated.

Fee-for-service funding payment models

Oral healthcare in Australia is predominately remunerated using the fee-for-service payment model, rewarding inputs rather than outcomes (Hegde and Haddock, 2022; Nguyen, 2017) and creating issues of equity and accessibility. For example, fee-for-service payment models are associated with higher risk of overtreatment and 1.5 times the rate of dental caries (Conquest et al., 2021).

Fee for service payment models, combined with free market competition and a growing supply of dentists has also been linked with rising costs, per dental visit (Grytten, 2017).

In Australia, the number of registered dental practitioners is trending upwards (DBA, 2020). However, the geographic distribution of the workforce remains problematic (Veginadu and Haddock, 2024) and there has been no concerted efforts to improve oral healthcare efficiencies through, for example, the optimal utilisation of oral health therapists (Nguyen et al., 2019; Nguyen and Hall, 2024).

The Australian Schedule of Dental Services and Glossary (ADA, 2022) has influenced the structure of government dental programs by supporting a fee-for-service payment model (Commonwealth of Australia, 2023a). However, this model presents challenges for advancing towards outcome-focused funding approaches, as there is currently no available data linking fee-for-service payments to patient outcomes (Productivity Commission, 2017).

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Review of fee-for-service dental programs

In Australia, a number of the fee for service dental programs have been reviewed, yet the release of findings has been delayed or not released at all, undermining government responses to the population's oral health needs. For example, The Department of Veterans' Affairs dental program underwent review in 2020; however, as of 2025, the findings have not yet been released (DVA, 2022).

Without access to findings, opportunities for evidence-informed improvements, such as enhancing access, ensuring/improving the provision quality of care or funding arrangements, may be missed. In another example, the means-tested Child Dental Benefits Schedule (CDBS) dental program has been reviewed five times since its implementation in 2014, with recommendations often taking a long time to implement or even failing to be implemented before subsequent reviews take place (Bastani et al., 2022).

A review of eight independent Australian state and territory public dental programs, delivered by salaried dental practitioners, has identified significant challenges linked to the continued use of fee-for-service payment models (Productivity Commission, 2017), including:

- higher rates of dental extractions being performed in the public dental programs, and
- lower rates of preventive dental services, when compared to the private sector under government subsidised oral healthcare (Brennan et al., 2008, 1997; Nguyen et al., 2022).

To better align dental services with consumer needs, Australian governments should develop an evidence-based dental fee schedule that prioritises prevention and early intervention.

This schedule should be tailored to reflect individuals' oral health risks and needs, supporting more targeted and effective care delivery (Productivity Commission, 2017).

There is a prevailing assumption that consumers are generally equipped to make informed decisions about their dental care (Grytten and Sørensen, 2000; Moeller and Quiñonez, 2020). However, this is not always the case and low levels of oral health literacy are not only associated with increased economic barriers to accessing oral health care, but also poorer oral health outcomes (Alzahrani et al., 2025; King et al., 2023).

Cost-effectiveness of oral healthcare

In Australia, the growing burden of oral disease likely reflects systemic inefficiencies in healthcare, partly driven by the high costs of dental services.

The 2024 Australian Burden of Disease Study indicates that the lack of timely access to oral healthcare has contributed to an increased burden of dental caries and periodontitis between 2003 and 2024 (AIHW, 2024c), as measured in disability-adjusted life years (DALYs) (Figure 3).[6] These inefficiencies occur against a backdrop of considerable progress in our understanding of oral disease prevention and advances in technologies in dentistry worldwide (Watt et al., 2019).

Within the Australian context, there are significant knowledge gaps in our understanding of the cost-effectiveness of oral health preventive interventions (Eow, 2019; Nguyen et al., 2023b; Rogers et al., 2019; Tonmukayakul et al., 2015). This potentially hinders efforts to increase investment in oral healthcare.

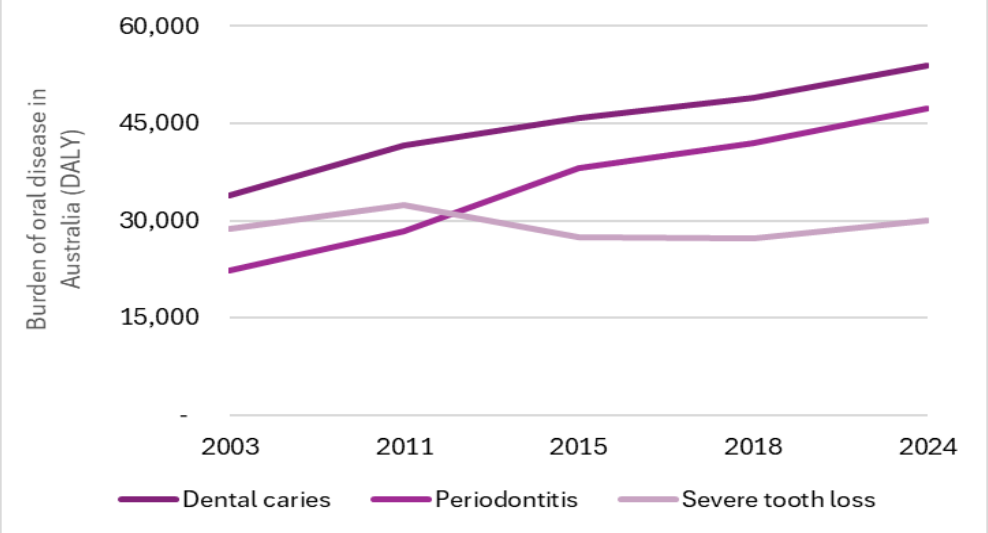

Figure 3: Burden of oral disease in Australia; trends in disability-adjusted life years (DALY) on the three most common oral conditions, (2003-2024) (AIHW, 2024a).

[6] Figure 3.1 interactive for Australian Burden of Disease Study 2024.

Universal access to essential oral healthcare

For example, six-monthly dental check-ups and professional teeth cleaning continue to be widely practiced internationally, including in Australia, despite limited evidence supporting their cost-effectiveness (Fee et al., 2020; Lamont et al., 2018). This practice, while maintaining a preventative focus, may not always be clinically necessary and therefore represents low-value care when applied universally. Avoidable, unnecessary oral healthcare costs, such as overtreatment and missed opportunities to reorient health services that generate high value for consumers and funders exacerbate this issue (Innes and Schwendicke, 2017; Keys et al., 2019; Lin et al., 2023; Vujicic and David, 2023).

Some progress towards value-based care has been achieved through the adoption of health outcome measures that support policy efforts to prioritise prevention (Nguyen et al., 2023).

For example, the economic evaluation of expanding community water fluoridation in Australia, which supports its implementation in communities with populations of at least 1,000 people has strengthened advocacy efforts and informed public health planning (Cobiac and Vos, 2012; Nguyen et al., 2025).

The modelled impact of a 20% sugar-sweetened beverages tax in Australia (Nguyen et al., 2023a) has demonstrated an almost 10-fold cost-saving benefit ($23.4 million vs $2.6 million) and three-fold health benefit (30.8 DALYs averted vs 10.2 DALYs averted) to populations who were most socioeconomically disadvantaged compared to the least socioeconomically disadvantaged (Nguyen et al., 2023a).

Although a sugar-sweetened tax has been implemented in over 130 jurisdictions in 120 countries and territories (Cancer Australia, 2025), this public health intervention is yet to be adopted in Australia.

Targeted funding: Government subsidised oral healthcare

The exclusion of dentistry from Australia's universal health coverage has led to a fragmented and inequitable approach to oral healthcare access (Parliament of Australia, 2023; Nguyen et al, 2025). In response, funding has largely been targeted to address specific gaps in affordability and availability.

However, this approach has introduced further complexity and inconsistency, as individual oral health needs are shaped by personal preferences and circumstances, making it difficult for targeted interventions to deliver equitable and coordinated care at a system level.

This is highlighted in the 2024 Mirror, Mirror Commonwealth Fund report that compares healthcare system performance across high-income countries.[7] Although Australia ranks first overall, it performs poorly (9th out of 10 countries) in cost-related access to healthcare, which, includes dental care (Blumenthal et al., 2024).

This position in oral healthcare affordability contrasts with countries, such as Germany, Denmark, Finland, France, Sweden, and the United Kingdom which have implemented universal health coverage models that explicitly include oral health services (Winkelmann et al., 2022). In these settings, government subsidised oral healthcare is consistently linked to improved oral health outcomes at the population level (Nguyen et al., 2023; Raittio and Suominen, 2022).

However, variation between countries around what type of dental services are covered, the composition of the oral health workforce, and the cost-sharing models of financing make it difficult to compare between systems to understand the 'ideal' oral healthcare funding model.

Among a broad set of aggregated performance indicators, including unmet needs for dental care, OECD countries with a greater share of government funded healthcare expenditure tend to demonstrate high system efficiency (Molander, 2025).

Targeted oral healthcare for children

In Australia, efforts to expand universal access to oral healthcare have primarily focused on targeted funding for children. A key example being the Australian School Dental Program (ASDP: 1974-1982), a cost-shared initiative between the Commonwealth, state, and territory governments that supported the development and delivery of school-based dental services (Akers et al., 2017).

Despite the program's demonstrated success, evidenced by reductions in the number of decayed, missing, and filled teeth, as well as improvements in children's oral hygiene (Carr, 1982), the ASDP was discontinued following shifts in federal policy priorities under a change in Commonwealth government (Wright and List, 2012).

[7] Canada, France, Germany, Netherlands, New Zealand, Sweden, Switzerland, United Kingdon and United States.

Since the closure of the Program, reforms to children's oral health funding in Australia have been largely piecemeal and reactive, lacking a sustained and strategic approach.

Initiatives such as the means-tested Commonwealth Dental Health Program, the Private Health Insurance Rebate Scheme, the Medicare Teen Dental Plan, and the Child Dental Benefits Schedule have each aimed to improve access (Figure 4), but none have provided a comprehensive or universal solution to financial protection.

Commonwealth Dental Health Program (1994-1997)

The Commonwealth Dental Health Program (CDHP), delivered through state and territory public dental services, aimed to provide comprehensive oral healthcare to low-income populations, including children. The program was discontinued following a change in Commonwealth government (Wright and List, 2012) and was subsequently replaced in 1997 by the Private Health Insurance Rebate Scheme (PHIRS), which shifted the focus toward subsidising private dental care.

Private Health Insurance Rebate Scheme (1997-present)

The means-tested PHIRS provided government subsidies for oral healthcare, but only to individuals who could afford private health insurance. The scheme offers tiered rebate levels based on household income thresholds, reinforcing inequities in access to care (Robson and Paolucci, 2012).

Medicare Teen Dental Plan (2008-2013)

Introduced in 2008 alongside PHIRS, the Medicare Teen Dental Plan (MTDP) provided an annual dental benefit of $150 as a bundled capitation payment for preventive services—such as check-ups, cleaning, radiographs, fissure sealants, and fluoride application, targeted at children aged 12–17 years.

However, government evaluations revealed inequitable utilisation. Children from the most advantaged areas accessed the program at nearly twice the rate (29%) of those from the least advantaged areas (16%) (ANAO, 2015; Commonwealth of Australia, 2009).

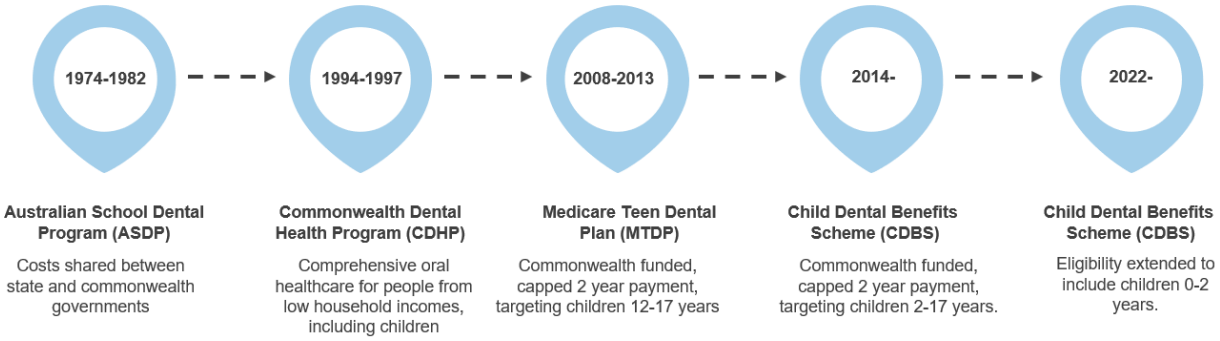
1974-1982
1994-1997
2008-2013
2014-
2022-
Australian School Dental Program (ASDP)
Costs shared between state and commonwealth governments
Commonwealth Dental Health Program (CDHP)
Comprehensive oral healthcare for people from low household incomes, including children
Medicare Teen Dental Plan (MTDP)
Commonwealth funded, capped 2 year payment, targeting children 12-17 years
Child Dental Benefits Scheme (CDBS)
Commonwealth funded, capped 2 year payment, targeting children 2-17 years.
Child Dental Benefits Scheme (CDBS)
Eligibility extended to include children 0-2 years.

Figure 4: Government subsidised oral healthcare for children in Australia (Akers et al., 2017; Wright and List, 2012).

Geographic disparities were also evident, with uptake ranging from 20–25% across New

Universal access to essential oral healthcare

South Wales (Skinner et al., 2012). While comparable data for other states is limited, national evaluations indicate that children in more advantaged regions consistently accessed the program at higher rates than those in disadvantaged or remote areas (ANAO, 2015).

These patterns reflect broader social determinants of oral health, where barriers extend beyond financial cost to include geographic, cultural, and systemic factors (Bastos and Borde, 2023; Fisher-Owens et al., 2007; Stormon et al., 2022; Stormon and Sowa, 2023).

In 2013, the MTDP was ceased in order to implement the Child Dental Benefits Scheme (CDBS), which arose from recommendations from the National Advisory Committee on Dental Health (ANAO, 2015; NACDH, 2012).

Child Dental Benefits Scheme (2014-present)

The Child Dental Benefits Schedule (CDBS) was introduced to extend the scope of the Medicare Teen Dental Plan (MTDP), aligning more closely with services traditionally delivered by state and territory public dental programs but now funded by the Australian Government. The CDBS expanded eligibility to children aged 0–17 years and broadened the range of services to include general dental treatments, excluding orthodontics (Bastani et al., 2022). To support this expanded coverage, the benefit cap was increased to $1,132 over two calendar years (Services Australia, 2025).

Despite these enhancements, the CDBS has consistently underperformed against its original utilisation target of 78% set in 2014. Current budget projections estimate utilisation at just 44% for the 2024–25 financial year (Commonwealth of Australia, 2024; Nguyen et al., 2021).

While there is some evidence of improved access among children from low-income households, estimated at a 6–8% increase (Nguyen et al., 2025; Stormon et al., 2022), comprehensive evaluations of the program's effectiveness and cost-effectiveness in improving oral health outcomes remain limited.

Fragmented and inequitable funding undermines efficiency

Australia's oral healthcare system is characterised by overlapping responsibilities between federal, state, and territory governments, leading to duplication in service delivery and inefficiencies in funding allocation (NACDH, 2012; Productivity Commission, 2017). The effectiveness of these fragmented arrangements remains unclear.

Additionally, eligibility criteria for public dental services vary significantly across jurisdictions, particularly for adults, while most states and territories offer broader coverage for children (Table 1) (Duckett et al., 2019; Nguyen, 2017).

This inconsistency contributes to inequitable access and complicates national efforts to improve oral health outcomes. This complexity has created confusion among consumers, primarily those from lower socioeconomic backgrounds, when seeking access to government subsidised oral healthcare in a timely manner (Commonwealth of Australia, 2023b).

Table 1: Government subsidised oral healthcare and population eligibility (Duckett et al., 2019; Nguyen, 2017).

Government subsidised oral healthcare	Funding source	Target Population		Dental service coverage
		Children	Adults	
State and territory dental programs	• Federal and state/territory • Department of Health and Aged Care • Federal Financial Agreement	Yes - variable eligibility based on age and may be means-tested	Yes - means tested	Comprehensive dental care following state and territory dental program clinical guidelines
Child Dental Benefits Schedule	• Federal • Department of Health and Aged Care • Dental Benefits Act 2008	Yes - means-tested	No	Comprehensive dental care except for orthodontic services
Public hospital admitted and outpatient services	• Federal and state/territory • Department of Health and Aged Care • National Health Reform Agreement	Yes	Yes	Limited dental care - acute dental conditions
Private health insurance	• Federal • Treasury	Yes - means-tested	Yes - means-tested	Comprehensive dental care
Royal Flying Doctors Service	• Federal • Block funding	Yes*	Yes*	Variable, targeted to rural and remote areas
Department of Veterans' Affairs	• Federal • Department of Veterans' Affairs	Yes*	Yes*	Comprehensive dental care Targeted to individuals who have served in the military, and family members
MBS, Cleft Lip and Palate Services	Federal Department of Health and Aged Care Health Insurance Act 1973	Yes*	No*	Comprehensive dental care Targeted to individuals who are diagnosed with a cleft lip and palate

While eligible children are typically exempt from public dental waitlists, adults often face delays of up to three years before receiving comprehensive care through state and territory programs (Productivity Commission, 2017). These delays contribute to a growing reliance on emergency dental services and preventable high-cost treatments.

In 2022–23 alone, there were 87,410 potentially preventable dental hospitalisations—representing an estimated $1.6 billion in avoidable healthcare costs (IHACPA, 2025). Timely access to oral healthcare through primary care settings could significantly reduce this burden. Across all age groups, children aged 5–9 years experience the highest rate of potentially preventable dental hospitalisations, at 12.3 per 1,000—more than three times the national average of 3.4 per 1,000 (AIHW, 2024e).

The majority of these hospitalisations are due to untreated dental caries, a largely preventable condition (Rogers et al., 2018).

These figures highlight a critical gap in early intervention and access to preventive oral healthcare for young children (see Figure 5)

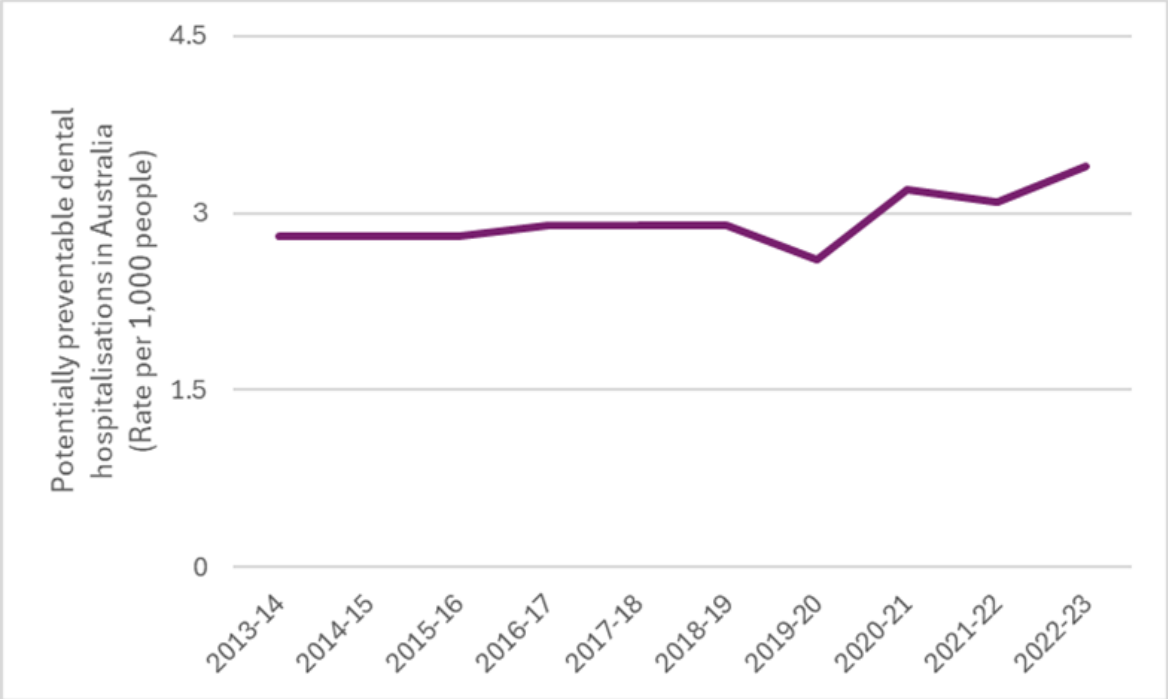

Figure 5: The trends in potentially preventable dental hospitalisations, 2013-14 to 2022-23 financial years (AIHW, 2024e). The reduced rate of potentially preventable dental hospitalisations in the 2019/20 financial year is likely due to COVID-19 pandemic restrictions to oral healthcare in Victoria (Nguyen et al., 2021)

Underfunding limits access and care quality

Government-subsidised oral healthcare in Australia remains under-resourced, limiting its capacity to meet growing consumer demand and making timely access unaffordable for many Australians (Commonwealth of Australia, 2023b).

Chronic underfunding of state and territory dental programs has resulted in a system that prioritises broad access over consumer-centred, evidence-based care. This has led to limited capacity for regular follow-ups and tailored treatment for individuals at higher risk of oral disease (Productivity Commission, 2017; VAGO, 2016).

Universal access to essential oral healthcare

For example, in 2011, approximately one-third of Australian adults were eligible for public dental services, yet around 200,000 adults remained on waiting lists (Dudko et al., 2017).

Despite multiple program evaluations, there remains limited visibility into who is benefiting from subsidised care and whether it is reaching those most in need (Productivity Commission, 2017; TAO, 2024; VAGO, 2016).

Inefficiencies in public spending through private health insurance

Compared to European oral healthcare systems, Australia provides limited government-funded dental coverage (Winkelmann et al., 2022). A significant portion, 61%, of the Australian government public oral health budget is directed toward

private dental insurance rebates (AIHW, 2024a), despite growing evidence that this model is inefficient and inequitable (Duckett et al., 2019; Law et al., 2014; Yang, 2014).

These rebates are tiered by income, disproportionately benefiting higher-income households with the means to purchase private insurance (Duckett et al., 2019; Hopkins et al., 2013; Teusner et al., 2015).

Moreover, private dental insurance operates under a fee-for-service model that has not been evaluated for cost-effectiveness. This model may incentivise low-value care and overtreatment, potentially leading to physical or financial harm for consumers (Fee et al., 2020; Lamont et al., 2018; Nguyen and Worthington, 2023).

For example, dentists vary widely in their use of dental restorations, applying them in 12% to 74% of cases, despite evidence favouring non-invasive, preventive approaches (Innes and Schwendicke, 2017). Such variation contributes to unnecessary costs for both consumers and taxpayers and undermines the efficiency of public investment in oral healthcare (Holden et al., 2021).

International comparisons show that Australia ranks poorly in terms of affordable access to adult oral healthcare, regardless of the funding model in place (Winkelmann et al., 2022).

Only Portugal, which also has limited oral healthcare coverage similar to Australia, ranks worse at 34% (2019) of the adult population reporting unmet needs for dental care due to cost (Winkelmann et al., 2022), compared to Australia at 32% (2021) (AIHW, 2024).

Lessons from European oral healthcare systems highlight the importance of clearly defining the scope and cost-sharing structure of services within a universal dental care framework (Winkelmann et al., 2022). For Australia, this means explicitly outlining which dental services are considered essential and what proportion of costs will be publicly funded.

These critical design elements have been largely absent from previous proposals for universal dental schemes, limiting their feasibility and long-term sustainability (Clarke and Cutler, 2024; Duckett et al., 2019; Parliamentary Budget Office, 2024).

Recommendations

The adoption of a staged approach to implementing a universal oral healthcare system (Figure 6) would strengthen financial protection, improve health outcomes, and support the development of a sustainable and equitable healthcare system that fully integrates oral health.

This should include: development of an evidence-based definition of essential oral healthcare; a priority setting framework approach to guide oral healthcare funding and integration of oral health into HTA processes.

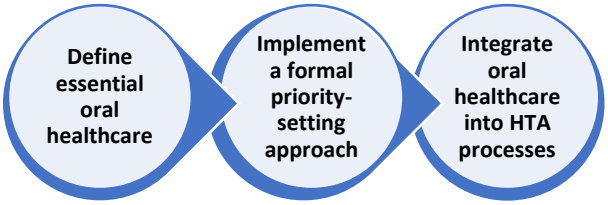
Define essential oral healthcare
Implement a formal priority-setting approach
Integrate oral healthcare into HTA processes

Figure 6: Staged approach to financial protection and enabling universal access to essential oral healthcare in Australia.

Recommendation 1: Define essential oral healthcare in Australia

In Australia, the absence of a nationally agreed, evidence-based definition of essential oral healthcare presents significant challenges in effective resource allocation and determining which dental services should receive government subsidies. This lack of consensus hampers efforts to establish a comprehensive and equitable oral healthcare framework.

To address this issue, Australia should adopt the WHO approach as the foundation for developing a national dental schedule that clearly defines essential oral healthcare services (Benzian et al., 2022; WHO, 2024).

The definition of universal oral healthcare coverage and the WHO framework for essential oral healthcare (Benzian et al., 2022; WHO, 2024).

Universal oral healthcare coverage

Definition and selection of essential interventions based on priorities, burden, resources available, feasibility of interventions, etc.

Agreement on coverage: population access and financial coverage, service arrangement and quality assurance

Essential oral healthcare

Interventions for the most prevalent oral health problems comprising:

An agreed set of safe, quality, and cost-effective interventions at the individual and community level

Promoting and protecting oral health, as well as preventing and treating common oral diseases appropriate rehabilitative services

Goal: maintain health, productivity, and quality of life

The WHO advises member states to undertake a structured national stakeholder engagement process to review scientific evidence, assess workforce capacity, and identify cost-effective oral health interventions (WHO, 2024).

Establishing a nationally agreed definition will enable the Australian Government to make informed resource allocation decisions, ensuring financial protection and equitable

access to care within the framework of universal health coverage.

This proposal could be further supported through coordinated action across state and territory jurisdictions, to oversee service delivery and workforce planning that enables flexible care models to be adapted locally, but meet national equity and quality standards

Historically, proposed universal dental schemes in Australia have primarily focused on services delivered by dental practitioners, often neglecting the critical role of non-dental health professionals in preventive oral healthcare (Han et al., 2024). Expanding the involvement of primary care providers, community health workers, and allied health professionals in preventive oral health strategies will enhance accessibility, affordability, and better health outcomes, particularly in rural and remote regions.

Given that primary healthcare professionals are the main providers of health services in rural and remote communities in Australia, they are well-positioned to offer dental services to prevent oral disease (e.g., screening for risk factors and application of topical fluorides). Therefore, it is crucial to include non-dental health practitioners in any framework for providing essential oral healthcare (Table 2).

This is aligned with the recommendations of the Independent Scope of Practice Review (DoHAC, 2024). Further work will be needed to explore how other dental services such as artificial intelligence, tele-dentistry and emerging technologies may meet the definition of essential oral healthcare.

Table 2: Proposed essential oral healthcare in Australia (Nguyen et al., 2025).

Description of services	Health practitioner service provider
Oral health screening and referral Oral health behaviour changes interventions Professional tropical fluoride therapy Oral health consultation (including oral examination, shared decision-making and oral healthcare plan) Periodontal maintenance Course of non-surgical periodontal therapy	Dental practitioners, medical practitioners, nurse practitioners and midwives, pharmacists and Aboriginal and Torres Strait Islander health practitioners working in non-dental primary health settings
Removal of tooth Repair of tooth with direct restorations Repair of tooth with indirect restorations Course of endodontic therapy Course of endodontic therapy Course of orthodontic treatment Course of orthodontic treatment with orthognathic surgery	Dental practitioners

Universal access to essential oral healthcare

Recommendation 2: Implement a formal priority -setting approach

To address persistent gaps in public funding and access to oral healthcare, Australia should establish a formal priority-setting framework to guide investment decisions in oral health services (COAG Health Council, 2015; Seixas et al., 2021).

A structured priority-setting approach enables policymakers to direct limited resources toward interventions that deliver optimal health outcomes based on agreed criteria, including cost-effectiveness, quality, and feasibility (Carter et al., 2008; Robinson et al., 2012; Teerawattananon et al., 2016).

Priority-setting mechanisms typically follow two interconnected steps (Carlsson, 2004):

- Filtration: Narrowing down health fields to identify priority areas.
- Selection: Choosing specific health fields or technologies for formal assessment.

In Australia, the MSAC and the PBAC serve as HTA bodies for evaluating health services and technologies under the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), respectively. These HTA processes focus primarily on the assessment of individual health services or pharmaceutical products for national funding inclusion (Angell et al., 2016; Whitty and Littlejohns, 2015).

By contrast, the Assessing Cost-Effectiveness (ACE) approach provides a broader, system-level framework for evaluating multiple health interventions simultaneously.

Through its structured six-step process (Figure 7), the ACE methodology is able to integrate technical economic analysis with stakeholder engagement, ensuring transparency, accountability, and policy relevance (Carter et al., 2008; Mihalopoulos et al., 2013).

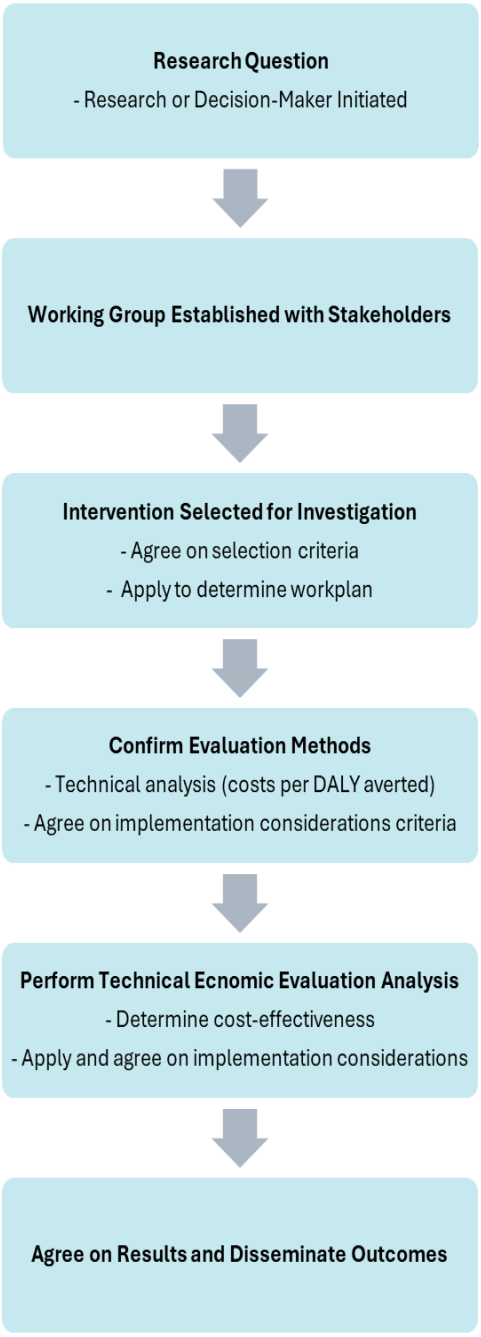
Research Question
- Research or Decision-Maker Initiated
Working Group Established with Stakeholders
Intervention Selected for Investigation
- Agree on selection criteria
- Apply to determine workplan
Confirm Evaluation Methods
- Technical analysis (costs per DALY averted)
- Agree on implementation considerations criteria
Perform Technical Ecnomic Evaluation Analysis
- Determine cost-effectiveness
- Apply and agree on implementation considerations
Agree on Results and Disseminate Outcomes

Figure 7: Six steps using the ACE priority-setting approach (adapted from Carter et al., 2008).

The ACE methodology extends beyond individual service assessments by incorporating key considerations such as cost-effectiveness, equity, and feasibility, supporting strategic investment decisions across health policy domains.

The ACE approach is particularly relevant to oral healthcare, where service delivery remains fragmented, the evidence base is inconsistent, and funding decisions must account for long-term population health impact and sustainability.

The ACE approach has been successfully applied in several health domains, including cancer (Carter et al., 2000), mental health (Vos et al., 2005 The ACE framework has been successfully applied in various health domains, including:

- Cancer care (Carter et al., 2000),
- Mental health (Vos et al., 2005),
- Obesity prevention (Carter et al., 2009),
- Public health initiatives (Ananthapavan et al., 2018; Le et al., 2020; Vos, 2010).

Application of ACE in oral health policy

The ACE–Oral Health Prevention study has assessed the cost-effectiveness and population-level impact of preventive interventions targeting dental caries and periodontitis (Bernabe et al., 2025; Nguyen et al., 2023b). Findings indicate that the ACE approach provides a consistent and evidence-based method for modelling and comparing oral health interventions, making it an ideal framework for guiding investment in essential oral healthcare services.

Given the significant fiscal implications associated with the implementation of universal dental care (Clarke and Cutler, 2024; Duckett et al., 2019; PBO, 2024), the ACE–Oral Health Prevention model offers a scalable and pragmatic approach to incrementally expanding public investment in oral health.

Its emphasis on evidence-based decision-making, equity, and cost-effectiveness makes it a valuable policy instrument for advancing universal access to essential oral health services.

Alignment with Value-Based Healthcare (VBHC)

While not synonymous with value-based healthcare (VBHC), the ACE methodology is closely aligned with VBHC principles. It supports high-value service identification, ensuring that investments maximise health benefits relative to cost, while flagging interventions of limited or uncertain value. The ACE methodology incorporates economic evaluation, which compares one intervention with another to determine whether the intervention is cost-effective and resource allocation.

This contrasts with VHBC, which centres on focusing on outcomes that matter most to consumers, relative to cost-efficiency. Given existing knowledge gaps in the cost-effectiveness of oral health prevention, applying ACE methodologies can inform strategic prioritisation, optimising healthcare resource allocation and service delivery.

In jurisdictions such as Victoria, where oral healthcare is increasingly being aligned with VBHC principles (Hegde et al., 2024; Lin et al., 2023; Nguyen et al., 2023), the ACE methodology provides a robust, evidence-based framework to enhance oral healthcare prioritisation and oral health funding policy sustainability.

Recommendation 3: Integrate oral healthcare into HTA processes

The Australian Government should enable dental services and dental practitioners into existing HTA processes to ensure evidence-based resource allocation and equitable access to essential oral healthcare.

International experience highlights the important role of HTA in guiding evidence-based investment in oral healthcare. For example, HTA agencies in Canada and the United Kingdom have demonstrated how economic evaluations can be used to inform decisions about the value, cost-effectiveness, and prioritisation of government subsidised oral healthcare.

Integrating oral health into national HTA processes can help optimise funding by focusing investment on high-value, evidence-based services that improve outcomes and reduce health inequities.

Canada's Drug Agency

Conducted evaluations on the effectiveness and economic value of interventions such as water fluoridation, school-based dental programs, and fluoride varnish application, helping to guide public funding decisions that balance cost with population health impact (Bhatia et al., 2023).

National Institute for Health and Care Excellence UK

Developed clinical guidelines and conducts economic evaluation of dental services, including recall intervals and preventive care, leading to more consistent, cost-effective service provision across the NHS (Coulthard et al., 2015; Pepper et al., 2016).

By enabling funding decisions for dental services and dental practitioners in Australia's existing HTA mechanisms, the Australian Government can adopt similar approaches from overseas, ensuring oral healthcare is evaluated alongside other health interventions for its contribution to value, equity, and sustainability within universal health coverage.

As a first step, the Health Technology Assessment Review Implementation Advisory Group (DoHAC, 2024b) could explore reforms that support the inclusion of dental practitioners in HTA decision-making, ensuring oral healthcare is appropriately prioritised within universal health coverage.

The Child Dental Benefits Schedule and state and territory dental programs should be reviewed through the lens of essential oral healthcare and health economics, to assess their effectiveness, equity, and value for public investment.

Aligning oral healthcare funding decisions with the Health Technology Assessment Policy and Methods Review (DoHAC, 2024c) will promote more equitable access and financial protection for all Australians.

References

ADVOCATE Consortium, Trescher, A.-L., Listl, S., Van Der Galien, O., Gabel, F., Kalmus, O., 2020. Once bitten, twice shy? Lessons learned from an experiment to liberalize price regulations for dental care. Eur J Health Econ 21, 425–436. https://doi.org/10.1007/s10198-019-01145-z

Akers, H.F., Weerakoon, A.T., Foley, M.A., McAuliffe, A.J., 2017. The Medicare Chronic Disease Dental Scheme: Historical, Scientific, Socio-political Origins. J Hist Dent 65, 46–62.

Alzahrani, A.Y., El Meligy, O., Bahdila, D., Aljawi, R., Bamashmous, N.O., Almushayt, A., 2025. Health and oral health literacy: A comprehensive literature review from theory to practice. Int J Paed Dentistry 35, 434–445. https://doi.org/10.1111/ipd.13255

Ananthapavan, J., Sacks, G., Brown, V., Moodie, M., Nguyen, P., Barendregt, J., Veerman, J., Mantilla Herrer, A., Lal, A., Peeters, A., Carter, R., 2018. Assessing Cost-Effectiveness of Obesity Prevention Policies in Australia 2018 (ACE-Obesity Policy). Melbourne: Deakin University, 2018.

Angell, B., Pares, J., Mooney, G., 2016. Implementing priority setting frameworks: Insights from leading researchers. Health Policy 120, 1389–1394. https://doi.org/10.1016/j.healthpol.2016.10.005

Australian Bureau of Statistics, 2024. Patient Experiences, 2023-24 financial year | Australian Bureau of Statistics [WWW Document]. URL https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release (accessed 1.30.25).

Australian Institute of Health and Welfare, 2024a. Health expenditure Australia 2022–23, Summary [WWW Document]. Australian Institute of Health and Welfare. URL https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2022-23/contents/summary (accessed 6.13.25).

Australian Institute of Health and Welfare, 2024b. Oral health and dental care in Australia, Costs [WWW Document]. Australian Institute of Health and Welfare. URL https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/costs (accessed 6.14.25).

Australian Institute of Health and Welfare, 2024c. Oral health and dental care in Australia, Summary [WWW Document]. Australian Institute of Health and Welfare. URL https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary (accessed 6.14.25).

Australian Institute of Health and Welfare, 2024d. Australian Burden of Disease Study 2024, Summary [WWW Document]. Australian Institute of Health and Welfare. URL https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/contents/summary (accessed 6.14.25).

Australian Institute of Health and Welfare, 2024e. Oral health and dental care in Australia, Hospitalisations [WWW Document]. Australian Institute of Health and Welfare. URL https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations (accessed 6.14.25).

Australian National Audit Office, 2014. Medicare Compliance Audits. The Auditor General Audit Report No. 26, 2013-14. Performance Audit. (accessed 4.7.25) https://www.anao.gov.au/sites/default/files/AuditReport_2013-2014_26.pdf

Australian National Audit Office, 2015. Administration of the Child Dental Benefits Schedule [WWW Document]. URL https://www.anao.gov.au/work/performance-audit/administration-child-dental-benefits-schedule (accessed 2.27.25).

Australian Taxation Office, 2024. Applications received and approved [WWW Document]. URL https://www.ato.gov.au/about-ato/research-and-statistics/in-detail/super-statistics/early-release/compassionate-release-of-super/applications-received-and-approved (accessed 2.3.25).

Bastani, P., Izadi, R., Manchery, N., Ha, D., Calache, H., George, A., Do, L., 2022. How does the dental benefits act encourage Australian families to seek and utilise oral health services? PLoS ONE 17, e0277152. https://doi.org/10.1371/journal.pone.0277152

Bastos, J.L., Borde, E., 2023. What do we mean by social determinants of oral health? The Journal of the American Dental Association S000281772300404X. https://doi.org/10.1016/j.adaj.2023.07.001

Beckers, B., Clarke, A., Gao, A., James, M., Morgan, R., 2024. Developments in Income and Consumption Across Household Groups | Bulletin – January 2024.

Benzian, H., Beltrán-Aguilar, E., Niederman, R., 2022. Essential oral health care and universal health coverage go hand in hand. The Journal of the American Dental Association 153, 1020–1022. https://doi.org/10.1016/j.adaj.2022.08.006

Bernabe, E., Marcenes, W., Abdulkader, R.S., Abreu, L.G., Afzal, S., Alhalaiqa, F.N., Al-Maweri, S., Alsharif, U., Anyasodor, A.E., Arora, A., Asgary, et al., 2025. Trends in the global, regional, and national burden of oral conditions from 1990 to 2021: a systematic analysis for the Global Burden of Disease Study 2021. The Lancet 405, 897–910. https://doi.org/10.1016/S0140-6736(24)02811-3

Bhatia, S., Mohanty, V., Balappanavar, A.Y., Chahar, P., Rijhwani, K., Gupta, R., 2023. Health technology assessment for oral health in the past decade: a scoping review. Int J Technol Assess Health Care 39, e18. https://doi.org/10.1017/S0266462322003312

Blumenthal, D., Gumas, E., Shah, A., Gunja, M., Williams II, R., 2024. Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System [WWW Document]. https://doi.org/10.26099/ta0g-zp66

Brennan, D.S., Luzzi, L., Chrisopoulos, S., 2020. Use of dental services among Australian adults in the National Study of Adult Oral Health (NSAOH) 2017–18. Australian Dental Journal 65. https://doi.org/10.1111/adj.12768

Brennan, D.S., Luzzi, L., Roberts-Thomson, K.F., 2008. Dental service patterns among private and public adult patients in Australia. BMC Health Serv Res 8, 1. https://doi.org/10.1186/1472-6963-8-1

Brennan, D.S., Spencer, A.J., Slade, G.D., 1997. Service provision among adult public dental service patients: baseline data from the Commonwealth Dental Health Program. Australian and New Zealand Journal of Public Health 21, 40–44. https://doi.org/10.1111/j.1467-842X.1997.tb01652.x

Cancer Australia, 2025. Countries that have implemented taxes on sugar-sweetened beverages (SSBs) [WWW Document]. Obesity

Evidence Hub. URL https://www.obesityevidencehub.org.au/collections/prevention/countries-that-have-implemented-taxes-on-sugar-sweetened-beverages-ssbs (accessed 3.24.25).

Carlsson, P., 2004. Health technology assessment and priority setting for health policy in Sweden. Int J Technol Assess Health Care 20, 44–54. https://doi.org/10.1017/S0266462304000777

Carr, L.M., 1982. Dental health of children in Australia 1977–1980. Australian Dental Journal 27, 169–175. https://doi.org/10.1111/j.1834-7819.1982.tb04082.x

Carter, R., Moodie, M., Markwick, A., Magnus, A., Vos, T., Swinburn, B., Haby, M.M., 2009. Assessing Cost-Effectiveness in Obesity (ACE-Obesity): an overview of the ACE approach, economic methods and cost results. BMC Public Health 9, 419. https://doi.org/10.1186/1471-2458-9-419

Carter, R., Stone, C., Vos, T., Hocking, J., Mihalopoulos, C., Peacock, S., Crowley, S., 2000. Trial of Program Budgetting and Marginal Analysis (PBMA) to assist cancer control planning in Australia.

Carter, R., Vos, T., Moodie, M., Haby, M., Magnus, A., Mihalopoulos, C., 2008. Priority setting in health: origins, description and application of the Australian Assessing Cost–Effectiveness initiative. Expert Review of Pharmacoeconomics & Outcomes Research 8, 593–617. https://doi.org/10.1586/14737167.8.6.593

Clarke, P., Cutler, H., 2024. A Proposal to Extend Universal Insurance to Dental Care in Australia. Australian Economic Review 1467-8462.12556. https://doi.org/10.1111/1467-8462.12556

COAG Health Council, 2015. Australia's National Oral Health Plan 2015-2024.

Cobiac, L.J., Vos, T., 2012. Cost-effectiveness of extending the coverage of water supply fluoridation for the prevention of dental caries in Australia. Community Dent Oral Epidemiol 40, 369–376. https://doi.org/10.1111/j.1600-0528.2012.00684.x

Commonwealth of Australia, 2024. PORTFOLIO BUDGET STATEMENTS 2024–25. BUDGET RELATED PAPER NO. 1.9. HEALTH AND AGED CARE PORTFOLIO [WWW Document]. URL https://www.health.gov.au/sites/default/files/2024-05/budget-2024-25-health-and-aged-care-portfolio-budget-statements.pdf (accessed 3.11.25).

Commonwealth of Australia, 2023a. Report on the Fifth Review of the Dental Benefi ts Act 2008.

Commonwealth of Australia, 2023b. The Senate - Select Committee into the Provision of and Access to Dental Services in Australia [WWW Document]. URL https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000078/toc_pdf/AsystemindecayareviewintodentalservicesinAustralia.pdf (accessed 1.11.24).

Commonwealth of Australia, 2009. Report on the Review of the Dental Benefits Act 2008 [WWW Document]. URL https://web.archive.org.au/awa/20190410011213mp_/http:/www.health.gov.au/internet/main/publishing.nsf/Content/5AE86FB9D21A8277CA257BF0001F952F/$File/DoHA%20Dental%20Benefits_LR.pdf (accessed 2.27.25).

Conquest, J.H., Gill, N., Sivanujan, P., Skinner, J., Kruger, E., Tennant, M., 2021. Systematic Literature Review of Capitation and Fee-for-Service Payment Models for Oral Health

Services: An Australian Perspective. Healthcare 9, 1129. https://doi.org/10.3390/healthcare9091129

Coulthard, P., Craig, D., Holden, C., Robb, N.D., Sury, M., Chopra, S., Holroyd, I., 2015. Current UK dental sedation practice and the "National Institute for Health and Care Excellence" (NICE) guideline 112: sedation in children and young people. Br Dent J 218, E14–E14. https://doi.org/10.1038/sj.bdj.2015.338

Crocombe, L.A., Kraatz, J., Hoang, H., Qin, D., Godwin, D., 2015. Costly chronic diseases: a retrospective analysis of Chronic Disease Dental Scheme expenditure. Aust Health Rev 39, 448–452. https://doi.org/10.1071/AH14191

Dental Board of Australia, 2020. Dental Board of Australia - Health profession demographic snapshot [WWW Document]. URL https://www.ahpra.gov.au/documents/default.aspx?record=WD24%2f33513&dbid=AP&chksum=RMKhAF9EcIkdgksZr2nENw%3d%3d&_gl=1*dun7za*_ga*MTQ3NjAwNDYzMC4xNzQyNzk2NDA0*_ga_F1G6LRCHZB*MTc0Mjc5NjQwMy4xLjEuMTc0Mjc5NjQ4MC4wLjAuMA.. (accessed 3.24.25).

Department of Health and Aged Care, 2024a. Unleashing the Potential of our Health Workforce – Scope of Practice Review Final Report [WWW Document]. URL https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf (accessed 11.6.24).

Department of Health and Aged Care, 2024b. Health Technology Assessment Review Implementation Advisory Group – Terms of reference [WWW Document]. URL https://www.health.gov.au/sites/default/files/2024-12/health-technology-assessment-review-implementation-advisory-group-terms-of-reference.pdf (accessed 3.25.25).

Department of Health and Aged Care, 2024c. Health Technology Assessment Policy and Methods Review – Final report [WWW Document]. URL https://www.health.gov.au/sites/default/files/2024-09/health-technology-assessment-policy-and-methods-review-final-report_0.pdf (accessed 6.15.25).

Department of Veterans' Affairs, 2022. Dental Program Review [WWW Document]. Department of Veterans' Affairs. URL https://www.dva.gov.au/get-support/health-support/health-services/dental-care/dental-program-review (accessed 6.14.25).

Duckett, S., Matt, C., Swerissen, H., 2019. Filling the gap: A universal dental care scheme for Australia. Grattan Institute. URL https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf (accessed 9.16.22).

Dudko, Y., Kruger, E., Tennant, M., 2017. A national analysis of dental waiting lists and point-in-time geographic access to subsidised dental care: can geographic access be improved by offering public dental care through private dental clinics? Rural Remote Health 17. https://doi.org/10.22605/RRH3814

Eow, J., 2019. What evidence do economic evaluations in dental care provide? A scoping review. Community Dental Health 118–125. https://doi.org/10.1922/CDH_4426Eow08

Fee, P.A., Riley, P., Worthington, H.V., Clarkson, J.E., Boyers, D., Beirne, P.V., 2020. Recall intervals for oral health in primary care patients. Cochrane Database of Systematic Reviews 2020. https://doi.org/10.1002/14651858.CD004346.pub5

Fisher-Owens, S.A., Gansky, S.A., Platt, L.J., Weintraub, J.A., Soobader, M.-J., Bramlett, M.D., Newacheck, P.W., 2007. Influences on Children's Oral Health: A Conceptual Model.

Pediatrics 120, e510–e520. https://doi.org/10.1542/peds.2006-3084

Fu D, Shu X, Zhou G, Ji M, Liao G, Zou L. Connection between oral health and chronic diseases. (2020). MedComm 14;6(1):e70052. doi: 10.1002/mco2.70052.

Gnanamanickam, E., Teusner, D., Arrow, P., Brennan, D., 2018. Dental insurance, service use and health outcomes in Australia: a systematic review. Australian Dental Journal 63, 4–13. https://doi.org/10.1111/adj.12534

Grytten, J., 2017. Payment systems and incentives in dentistry. Comm Dent Oral Epid 45, 1–11. https://doi.org/10.1111/cdoe.12267

Grytten, J., Sørensen, R., 2000. Competition and dental services. Health Econ. 9, 447–461. https://doi.org/10.1002/1099-1050(200007)9:5<447::AID-HEC529>3.0.CO;2-A

Han, C., Lin, C., Raichur, A., Hall, M., Nguyen, T.M., 2024. Leadership, regulatory approaches and policy to re-orientate health services towards health promotion. Health Promotion International 39, daae050. https://doi.org/10.1093/heapro/daae050

Hegde, S., Haddock, R., 2022. Deeble Issues Brief No. 49: A roadmap towards scalable value-based payments in Australian healthcare [WWW Document]. Australian Healthcare & Hospitals Association. URL https://ahha.asn.au/publication/health-policy-issue-briefs/deeble-issues-brief-no-49-roadmap-towards-scalable-value (accessed 8.15.23).

Hegde, S., McKee, S., Cole, D., Wainer, Z., 2024. Experiences and learnings from developing and implementing a co-designed value-based healthcare framework within Victorian public oral health sector. Aust. Health Rev. 48, 134–141. https://doi.org/10.1071/AH24017

Holden, A.C.L., 2018. Consumer-driven and commercialised practice in dentistry: an ethical and professional problem? Med Health Care and Philos 21, 583–589. https://doi.org/10.1007/s11019-018-9834-1

Holden, A.C.L., Adam, L., Thomson, W.M., 2022. Dentists' Perspectives on Commercial Practices in Private Dentistry. JDR Clinical & Translational Research 7, 29–40. https://doi.org/10.1177/2380084420975700

Holden, A.C.L., Adam, L., Thomson, W.M., 2021. Overtreatment as an ethical dilemma in Australian private dentistry: A qualitative exploration. Comm Dent Oral Epid 49, 201–208. https://doi.org/10.1111/cdoe.12592

Hopcraft, M., 2024. Commentary on the senate select committee into the provision of and access to dental services in Australia: an opportunity for reform. Australian Dental Journal 69, 162–174. https://doi.org/10.1111/adj.13012

Hopkins, S., Kidd, M.P., Ulker, A., 2013. Private Health Insurance Status and Utilisation of Dental Services in Australia*. Economic Record 89, 194–206. https://doi.org/10.1111/1475-4932.12040

Independent Health and Aged Care Pricing Authority, 2025. NWAU calculators [WWW Document]. URL https://www.ihacpa.gov.au/health-care/pricing/nwau-calculators (accessed 9.3.23).

Innes, N.P.T., Schwendicke, F., 2017. Restorative Thresholds for Carious Lesions: Systematic Review and Meta-analysis. J Dent Res 96, 501–508. https://doi.org/10.1177/0022034517693605

Universal access to essential oral healthcare

Keys, T., Burrow, M., Rajan, S., Rompre, P., Doméjean, S., Muller-Bolla, M., Manton, D., 2019. Carious lesion management in children and adolescents by Australian dentists. Australian Dental Journal 64, 282–292. https://doi.org/10.1111/adj.12710

King, S., Thaliph, A., Laranjo, L., Smith, B.J., Eberhard, J., 2023. Oral health literacy, knowledge and perceptions in a socially and culturally diverse population: a mixed methods study. BMC Public Health 23, 1446. https://doi.org/10.1186/s12889-023-16381-5

Kraatz, J., Qin, D., Hoang, H., Godwin, D., Crocombe, L.A., 2014. Regional use of the Australian Chronic Disease Dental Scheme. Aust J Rural Health 22, 310–315. https://doi.org/10.1111/ajr.12121

Lam, R., 2012. Experiences in the implementation of a national policy: a retrospective analysis of the Australian Chronic Dental Disease Scheme. AMJ 5, 551–559. https://doi.org/10.4066/AMJ.2012.1479

Lam, R., Kruger, E., Tennant, M., 2015. Conundrums in merging public policy into private dentistry: experiences from Australia's recent past. Aust. Health Review 39, 169. https://doi.org/10.1071/AH14038

Lam, R., Kruger, E., Tennant, M., 2014. JERM model of care: an in-principle model for dental health policy. Aust. J. Prim. Health 20, 311. https://doi.org/10.1071/PY13054

Lamont, T., Worthington, H.V., Clarkson, J.E., Beirne, P.V., 2018. Routine scale and polish for periodontal health in adults. Cochrane Database of Systematic Reviews 2020. https://doi.org/10.1002/14651858.CD004625.pub5

Law, M.R., Kratzer, J., Dhalla, I.A., 2014. The increasing inefficiency of private health insurance in Canada. CMAJ 186, E470–E474. https://doi.org/10.1503/cmaj.130913

Le, L.K.-D., Hay, P., Ananthapavan, J., Lee, Y.Y., Mihalopoulos, C., 2020. Assessing the Cost-Effectiveness of Interventions That Simultaneously Prevent High Body Mass Index and Eating Disorders. Nutrients 12, 2313. https://doi.org/10.3390/nu12082313

Lin, C.E., Nguyen, T.M., McGrath, R., Patterson, A., Hall, M., 2023. Dental Health Services Victoria value-based health care principles for oral health models of care. Journal of Public Health Dentistry n/a. https://doi.org/10.1111/jphd.12581

Mihalopoulos, C., Carter, R., Pirkis, J., Vos, T., 2013. Priority-setting for mental health services. Journal of Mental Health 22, 122–134. https://doi.org/10.3109/09638237.2012.745189

Moeller, J., Quiñonez, C.R., 2020. Dentistry's social contract is at risk. The Journal of the American Dental Association 151, 334–339. https://doi.org/10.1016/j.adaj.2020.01.022

Molander, P., 2025. Public versus private healthcare systems in the OECD area– a broad evaluation of performance. Eur J Health Econ. https://doi.org/10.1007/s10198-025-01767-6

Naidoo, Y., Wong, M., Smyth, C., Davidson, P., 2024. Material deprivation in Australia: the essentials of life. UNSW Sydney. https://doi.org/10.26190/UNSWORKS/30746

National Advisory Council on Dental Health, 2012. Report of the National Advisory Council on Dental Health [WWW Document]. Trove. URL https://webarchive.nla.gov.au/awa/20120317050730/http://www.health.gov.au/internet/m

ain/publishing.nsf/Content/A1972FE9D3527C51CA2579B0007737CE/$File/Final%20Report%20of%20the%20NACDH%20-%2026%20February%202012%20(PUBLICATION).pdf (accessed 3.11.25).

Nguyen, H.T., Le, H.T., Connelly, L.B., 2021. Who's declining the "free lunch"? New evidence from the uptake of public child dental benefits. Health Econ 30, 270–288. https://doi.org/10.1002/hec.4200

Nguyen, L., Connelly, L.B., Birch, S., Nguyen, H.T., 2025. Change in Dental Visits Among Eligible Children Under the Impact of the Child Dental Benefits Schedule in Australia. Comm Dent Oral Epid cdoe.13036. https://doi.org/10.1111/cdoe.13036

Nguyen, L., Worthington, A.C., 2023. Moral hazard in Australian private health insurance: the case of dental care services and extras cover. Geneva Pap Risk Insur Issues Pract 48, 157–176. https://doi.org/10.1057/s41288-021-00245-3

Nguyen, T., 2017. Deeble Institute Issues Brief No. 20: Is the current model of public dental care promoting the oral health of young children in Australia? [WWW Document]. Australian Healthcare & Hospitals Association. URL https://ahha.asn.au/system/files/docs/publications/deeble_institute_paper_20_oral_health.pdf (accessed 9.21.22).

Nguyen, T., Bridge, G., Hall, M., Theodore, K., Lin, C., Scully, B., Heredia, R., Le, L.K.-D., Mihalopoulos, C., Calache, H., 2023. Is value-based healthcare a strategy to achieve universal health coverage that includes oral health? An Australian case study. J Public Health Pol. https://doi.org/10.1057/s41271-023-00414-9

Nguyen, T., Sexton, C., Do, L., 2025. Why policy relevant research still matters for community water fluoridation. Australian Dental Journal n/a. https://doi.org/10.1111/adj.13063

Nguyen, T.M., Hall, M., 2024. A policy option towards improving efficiencies in Victorian public oral healthcare. Health Planning & Management hpm.3824. https://doi.org/10.1002/hpm.3824

Nguyen, T.M., Lin, C., Hall, M., Calache, H., 2025. Mapping essential oral healthcare for the Australian context. Aust. Health Review 49. https://doi.org/10.1071/AH24298

Nguyen, T.M., Tonmukayakul, U., Calache, H., 2022. Evaluation of an intervention to promote minimally invasive dentistry (MID) in an Australian community dental agency—A pilot study. International Journal of Dental Hygiene 20, 627–634. https://doi.org/10.1111/idh.12523

Nguyen, T.M., Tonmukayakul, U., Calache, H., 2021. Dental Restrictions to Clinical Practice during the COVID-19 Pandemic: An Australian Perspective. JDR Clinical & Translational Research 6, 291–294. https://doi.org/10.1177/23800844211000341

Nguyen, T.M., Tonmukayakul, U., Calache, H., 2019. A dental workforce strategy to make Australian public dental services more efficient. Hum Resour Health 17, 37. https://doi.org/10.1186/s12960-019-0370-8

Nguyen, T.M., Tonmukayakul, U., Khanh-Dao Le, L., Singh, A., Lal, A., Ananthapavan, J., Calache, H., Mihalopoulos, C., 2023a. Modeled health economic and equity impact on dental caries and health outcomes from a 20% sugar sweetened beverages tax in Australia. Health Economics hec.4739. https://doi.org/10.1002/hec.4739

Nguyen, T.M., Tonmukayakul, U., Le, L.K.-D., Calache, H., Mihalopoulos, C., 2023b. Economic Evaluations of Preventive Interventions for Dental Caries and Periodontitis: A Systematic Review. Appl Health Econ Health Policy. https://doi.org/10.1007/s40258-022-00758-5

Palfreeman, V., Zoellner, H., 2012. Description of comprehensive dental services supported by the Medicare Chronic Disease Dental Scheme in the first 23 months of operation. Australian and New Zealand Journal of Public Health 36, 69–75. https://doi.org/10.1111/j.1753-6405.2011.00807.x

Parliamentary Budget Office, 2024. Various policy options for reforming Commonwealth subsidies of dental services | pbo [WWW Document]. URL https://www.pbo.gov.au/sites/default/files/2023-11/For%20publication%20PR-2023-367-Various%20policy%20options%20for%20reforming%20Commonwealth%20subsidies%20of%20dental%20services%20-%20PRR_0.pdf (accessed 2.9.25).

Parliament of Australia. Senate Select Committee into the Provision of and Access to Dental Services in Australia. (2023). *Final Report*. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Dental_Services_in_Australia/DentalServices/Final_report. (accessed 4.7.25)

Pepper, T., Konarzewski, T., Grimshaw, P., Combes, J., 2016. Treatment of mandibular third molars and pericoronitis in British military personnel: influence of guidelines from the National Institute for Health and Clinical Excellence. British Journal of Oral and Maxillofacial Surgery 54, 1111–1115. https://doi.org/10.1016/j.bjoms.2016.08.005

Productivity Commission, 2017. Introducing competition and informed user choice into Human Services: inquiry report. Commonwealth of Australia, Canberra, ACT.

Raittio, E., Suominen, A.L., 2022. Effects of universal oral healthcare coverage in an adult population: A long-term nationwide natural experiment. Comm Dent Oral Epid cdoe.12785. https://doi.org/10.1111/cdoe.12785

Robinson, S., Williams, I., Dickinson, H., Freeman, T., Rumbold, B., 2012. Priority-setting and rationing in healthcare: Evidence from the English experience. Social Science & Medicine 75, 2386–2393. https://doi.org/10.1016/j.socscimed.2012.09.014

Robson, A., Paolucci, F., 2012. Private Health Insurance Incentives in Australia: The Effects of Recent Changes to Price Carrots and Income Sticks. Geneva Pap Risk Insur Issues Pract 37, 725–744. https://doi.org/10.1057/gpp.2012.38

Rogers, H.J., Rodd, H.D., Vermaire, J.H., Stevens, K., Knapp, R., El Yousfi, S., Marshman, Z., 2019. A systematic review of the quality and scope of economic evaluations in child oral health research. BMC Oral Health 19, 132. https://doi.org/10.1186/s12903-019-0825-2

Rogers, J.G., Adams, G.G., Wright, F.A.C., Roberts-Thomson, K., Morgan, M.V., 2018. Reducing Potentially Preventable Dental Hospitalizations of Young Children: A Community-Level Analysis. JDR Clinical & Translational Research 3, 272–278. https://doi.org/10.1177/2380084418764312

Sanders A and Spencer J. 2004 Job characteristics and the subjective oral health of Australian workers. ANZJPH. 28 (3): 259-266.

Seixas, B.V., Dionne, F., Mitton, C., 2021. Practices of decision making in priority setting and resource allocation: a scoping review and narrative synthesis of existing frameworks. Health Econ Rev 11, 2. https://doi.org/10.1186/s13561-020-00300-0

Services Australia, 2025. What's covered by the Child Dental Benefits Schedule - Child Dental Benefits Schedule - Services Australia [WWW Document]. URL https://www.servicesaustralia.gov.au/whats-covered-child-dental-benefits-schedule?context=22426 (accessed 2.27.25).

Singhal S, Correa E and Quinonez C (2013). The impact of dental treatment on employment outcomes: A systematic review. Health Policy. 109 (1) 88-96.

Skinner, J.C., List, P., Wright, C., 2012. Utilisation of the Medicare Teen Dental Plan in NSW, 2008 - 2010. NSW Public Health Bull. 23, 5. https://doi.org/10.1071/NB11048

Srivastava, P., Chen, G., Harris, A., 2017. Oral Health, Dental Insurance and Dental Service use in Australia. Health Economics 26, 35–53. https://doi.org/10.1002/hec.3272

Stormon, N., Do, L., Sexton, C., 2022. Has the Child Dental Benefits Schedule improved access to dental care for Australian children? Health Social Care Comm 30. https://doi.org/10.1111/hsc.13803

Stormon, N., Sowa, M., 2023. Child Dental Benefits Schedule Subsidised Existing Utilisation of Dental Care over Addressing Unmet Needs. Health & Social Care in the Community 2023, 1–10. https://doi.org/10.1155/2023/5764573

Tasmanian Audit Office, 2024. Access to oral health services - Tasmanian Audit Office [WWW Document]. URL https://www.audit.tas.gov.au/publication/access-to-oral-health-services/ (accessed 10.2.24).

Teerawattananon, Y., Luz, A., Kanchanachitra, C., Tantivess, S., 2016. Role of priority setting in implementing universal health coverage. BMJ i244. https://doi.org/10.1136/bmj.i244

Teusner, D., Brennan, D., Spencer, A., 2015. Associations between level of private dental insurance cover and favourable dental visiting by household income. Aust Dent J 60, 479–489. https://doi.org/10.1111/adj.12268

The Australian Dental Association, 2022. The Australian Schedule of Dental Services and Glossary 13th Edition [WWW Document]. ADA. URL https://www.ada.org.au/Dental-Professionals/Publications/Schedule-and-Glossary/The-Australian-Schedule-of-Dental-Services-and-(2) (accessed 10.7.22).

Tonmukayakul, U., Calache, H., Clark, R., Wasiak, J., Faggion, C.M., 2015. Systematic Review and Quality Appraisal of Economic Evaluation Publications in Dentistry. J Dent Res 94, 1348–1354. https://doi.org/10.1177/0022034515589958

Veginadu, P., Haddock, R., 2024. Integrating oral health into primary healthcare for improved access to oral health care for rural and remote populations - AHHA. URL https://ahha.asn.au/wp-content/uploads/2024/06/Deeble-Issues-Brief-No.56-Integrating-oral-health-into-primary-healthcare.pdf (accessed 2.2.25).

Victorian Auditor General's Office, 2016. Access to public dental services in Victoria. Victorian Government Printer, Melbourne.

Vos, T., 2010. Assessing cost-effectiveness in prevention: (ACE-Prevention) : final report. Centre for Burden of Disease and Cost-Effectiveness, School of Population Health, University of Queensland, Brisbane.

Vos, T., Haby, M.M., Magnus, A., Mihalopoulos, C., Andrews, G., Carter, R., 2005. Assessing Cost-Effectiveness in Mental Health: Helping Policy-Makers Prioritize and

Plan Health Services. Aust N Z J Psychiatry 39, 701–712. https://doi.org/10.1080/j.1440-1614.2005.01654.x

Vujicic, M., David, G., 2023. Value-based care in dentistry. The Journal of the American Dental Association 154, 449–452. https://doi.org/10.1016/j.adaj.2023.04.001

Watt, R.G., Daly, B., Allison, P., Macpherson, L.M.D., Venturelli, R., Listl, S., Weyant, R.J., Mathur, M.R., Guarnizo-Herreño, C.C., Celeste, R.K., Peres, M.A., Kearns, C., Benzian, H., 2019. Ending the neglect of global oral health: time for radical action. Lancet 394, 261–272. https://doi.org/10.1016/S0140-6736(19)31133-X

Weerakoon, A., Fitzgerald, L., Porter, S., 2014. An Australian government dental scheme: Doctor-dentist-patient tensions in the triangle. J Forensic Odontostomatol 32 Suppl 1, 9–14.

Whitty, J.A., Littlejohns, P., 2015. Social values and health priority setting in Australia: An analysis applied to the context of health technology assessment. Health Policy 119, 127–136. https://doi.org/10.1016/j.healthpol.2014.09.003

Winkelmann, J., Gómez Rossi, J., van Ginneken, E., 2022. Oral health care in Europe: Financing, access and provision. Health Systems in Transition 24, 1–169.

World Dental Federation. https://www.fdiworlddental.org/ (accessed 9.7.25)

World Health Organization, 2024. Global strategy and action plan on oral health 2023–2030 [WWW Document]. URL https://iris.who.int/bitstream/handle/10665/376623/9789240090538-eng.pdf?sequence=1 (accessed 9.7.25).

Wright, F.A.C., List, P.F., 2012. Reforming the mission of public dental services. Comm Dent Oral Epid 40, 102–109. https://doi.org/10.1111/j.1600-0528.2012.00728.x

Yang, C.C., 2014. Health Care Reform, Efficiency of Health Insurers, and Optimal Health Insurance Markets. North American Actuarial Journal 18, 478–500. https://doi.org/10.1080/10920277.2014.935438

Contact:

Adj AProf Rebecca Haddock
Executive Director Knowedge Exchange
Australian Healthcare and Hospitals Association Limited.
Email: rhaddock@ahha.asn.au

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